

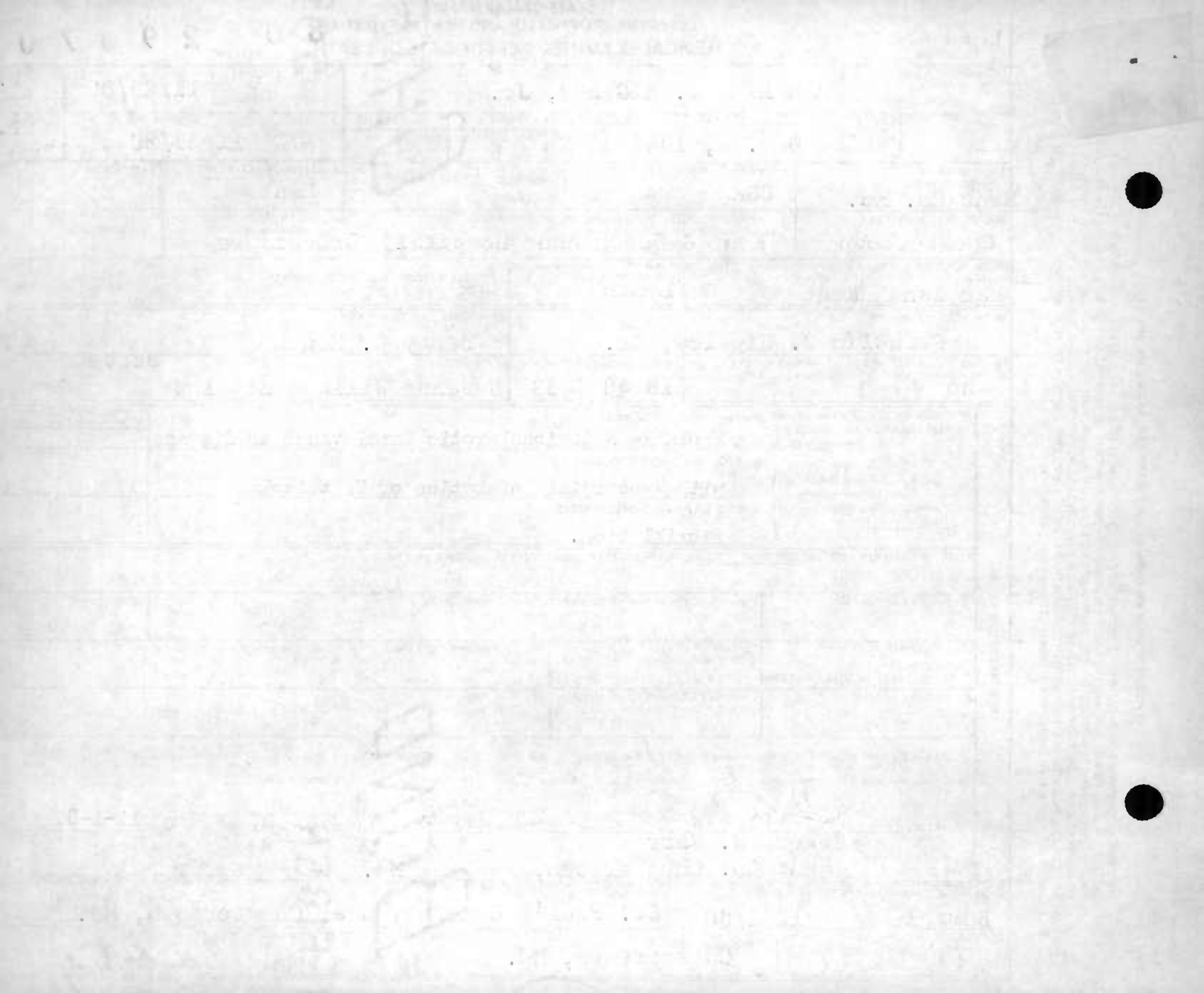
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 WEST BALTIMORE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND										8029070									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FRANKLIN P. BIGELOW, Jr.										2a. DATE KNOWN OF DEATH 11/29/80									
3. SEX male										4. RACE white									
5. DATE OF BIRTH Dec. 6, 1946										6. AGE (IN YEARS) 33									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.										7b. CITIZEN OF WHAT COUNTRY? USA									
8. MARRIED [X] NEVER MARRIED [] WIDOWED [] DIVORCED []										9. BALTIMORE CITY OR COUNTY OF DEATH Kent									
10. CITY OR TOWN OF DEATH Chestertown										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Kent & Queen Anne Hospital									
12a. USUAL OCCUPATION (TYPE OF WORK) Bracklayer										12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Maryland										13b. COUNTY Kent									
13c. CITY OR TOWN Lynch										13d. INSIDE CITY LIMITS? YES [X] NO []									
13e. STREET ADDRESS										14. FATHER'S NAME Franklin P. Bigelow, Sr.									
15. MOTHER'S MAIDEN NAME Betty C. Mench										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? no									
16b. SOCIAL SECURITY NO. 218 48 7453										17. INFORMANT ADDRESS above									
17. INFORMANT Susanne Willson Bigelow										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Arteriosclerotic Cardiovascular disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										(b) with Myocardial Infarction or Ventricular									
(c) Fibrillation.										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
20. AUTOPSY? YES [] NO [X]										21a. EXTERNAL CAUSE WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE [] NOT WHILE [] AT WORK [] AT WORK []										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE										22a. I certify that I took charge of the remains described above, held on Autopsy [], Inspection [X], Inquiry [], and in my opinion death resulted from: Natural causes [X], Accident [], Suicide [], Homicide [], Undetermined manner [].									
22b. TITLE (SPECIFY) Deputy										22c. MEDICAL EXAMINER									
22d. DATE SIGNED 12-1-80										22e. EXAMINER'S NAME Robert W. Farr									
22f. EXAMINER'S NAME (TYPE OR PRINT) Kent Co. Chestertown, Md.										23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial									
23b. DATE 12/2/80										23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery									
23d. LOCATION CITY OR TOWN near Chestertown, Md.										23e. COUNTY STATE									
24. FUNERAL DIRECTOR Willis Wells										24a. DATE REC'D. BY REGISTRAR DEC 3 1980									
24b. REGISTRAR'S SIGNATURE										24c. REGISTRAR'S SIGNATURE									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Gertrude Bright			November 8, 1980		9:50A M	
3 SEX Female	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR May 15, 1913	6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.		
10 CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent and Queen Anne's Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian -Kent		12b KIND OF BUSINESS OR INDUSTRY County Board of Education	
13a STATE Maryland		13b COUNTY Kent	13c CITY OR TOWN Worton	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS Rt. #1 Box #68	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel James Johnson			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosie NMN BROWN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-14-4534		17 INFORMANT ADDRESS Hoapital records-Chestertown, Maryland		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Mycinous Cyst Adenocarcinoma, Lt Ovary</u> <u>1830</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 weeks</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>November 7, 1980</u> to <u>November 8, 1980</u> , that (I) (we) last saw the deceased alive on <u>November 8, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <u>Charles P. Adamo MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>11/10/80</u>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Charles P. Adamo, M.D.		22e ADDRESS Chestertown, Maryland 21620				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN	COUNTY	STATE
<u>BURIAL</u>	<u>11-12-1980</u>	<u>FOUNTAIN CEM.</u>		<u>Chestertown</u>	<u>Kent</u>	<u>MD</u>
24 FUNERAL DIRECTOR NAME <u>Charles P. Adamo</u>		ADDRESS <u>Chestertown</u>		25a DATE REC'D. BY REGISTRAR <u>NOV 18</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 29072

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ida Mason Hill</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>Nov. 11 1980</i>		2b. HOUR <i>3:30 A.M.</i>	
3. SEX <i>F.</i>	4. RACE <i>W.</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 6 1891</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>89</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Kent</i> MD.	
10. CITY OR TOWN OF DEATH <i>Chesapeake</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Magnolia Hall</i>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Md.</i>	13b. COUNTY <i>Kent</i>	13c. CITY OR TOWN <i>Worton</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>Box P.M. Worton 21678</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank O. Mason</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie Giesse</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-36-1334</i>		17. INFORMANT ADDRESS <i>Mrs. Frances A. Gipe Box P.M. Worton Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Aortic Failure</i> <i>4392</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE OF PHYSICIAN <i>P.O. Moloney</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/12/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>P.O. Moloney</i>		22e. ADDRESS <i>Chestertown, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Nov 13/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Chesapeake Cemetery</i>	
23d. LOCATION CITY OR TOWN <i>Chestertown</i>		COUNTY <i>Kent</i>		STATE <i>Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Marvin V. Waller Jr</i>		ADDRESS <i>Chestertown, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 17 1980</i>	
				25b. REGISTRAR'S SIGNATURE <i>Henry McNeely</i>	

5-10-50

RECEIVED
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17
(VR A15 ME (5))
15M/77

FOR
1- STATE REGISTRAR
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

29073

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			2b. DATE OF ESTI-MATED			2c. DATE PRONOUNCED DEAD			2d. HOUR				
Joan Helen Duff						11-24 19 80			3:47 PM										
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Female		White		1-16-35		45 YRS.						Del.		USA				Kent MD	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Rt. 301 nr. Millington								Housewife				Home							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Cecil		Earlville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		235 Oriole Farm Lane											
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST						FIRST MIDDLE LAST													
Gilbert Hayes						A. Lizinia Carter Hayes													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS							
No.						215-32-4662						Harvey Duff, Sr., as above.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART 1 DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) <u>Multiple severe injury to chest, abdomen, and</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b) <u>head.</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
Auto accident, head on collision																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				3:47 PM 11-24 19 80				Auto accident											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
				U.S. 301 2 miles south of MD Rt. 313,				Kent, Maryland											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)										DATE SIGNED					
Robert W. Farr, M.D.				Deputy										11-25-80					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Robert W. Farr, M.D.				Chestertown, Maryland 21620															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				11/28/80				Silverbrook Cem.				Wilmington, N.C. Del.							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
NAME ADDRESS				21651				DEC 1 1980				[Signature]							
Edward Fellows & Son, Millington, Md.																			



Form with multiple sections and fields, including a header area with the text "U.S. DEPARTMENT OF AGRICULTURE" and "BUREAU OF PLANT INDUSTRY". The form contains various tables and sections for data entry, with some handwritten notes and a large circular stamp in the lower right corner.

Section 1		Section 2		Section 3	
1-1-1	1-1-2	1-1-3	1-1-4	1-1-5	1-1-6
1-1-7	1-1-8	1-1-9	1-1-10	1-1-11	1-1-12
1-1-13	1-1-14	1-1-15	1-1-16	1-1-17	1-1-18
1-1-19	1-1-20	1-1-21	1-1-22	1-1-23	1-1-24
1-1-25	1-1-26	1-1-27	1-1-28	1-1-29	1-1-30
1-1-31	1-1-32	1-1-33	1-1-34	1-1-35	1-1-36
1-1-37	1-1-38	1-1-39	1-1-40	1-1-41	1-1-42
1-1-43	1-1-44	1-1-45	1-1-46	1-1-47	1-1-48
1-1-49	1-1-50	1-1-51	1-1-52	1-1-53	1-1-54
1-1-55	1-1-56	1-1-57	1-1-58	1-1-59	1-1-60
1-1-61	1-1-62	1-1-63	1-1-64	1-1-65	1-1-66
1-1-67	1-1-68	1-1-69	1-1-70	1-1-71	1-1-72
1-1-73	1-1-74	1-1-75	1-1-76	1-1-77	1-1-78
1-1-79	1-1-80	1-1-81	1-1-82	1-1-83	1-1-84
1-1-85	1-1-86	1-1-87	1-1-88	1-1-89	1-1-90
1-1-91	1-1-92	1-1-93	1-1-94	1-1-95	1-1-96
1-1-97	1-1-98	1-1-99	1-1-100	1-1-101	1-1-102
1-1-103	1-1-104	1-1-105	1-1-106	1-1-107	1-1-108
1-1-109	1-1-110	1-1-111	1-1-112	1-1-113	1-1-114
1-1-115	1-1-116	1-1-117	1-1-118	1-1-119	1-1-120
1-1-121	1-1-122	1-1-123	1-1-124	1-1-125	1-1-126
1-1-127	1-1-128	1-1-129	1-1-130	1-1-131	1-1-132
1-1-133	1-1-134	1-1-135	1-1-136	1-1-137	1-1-138
1-1-139	1-1-140	1-1-141	1-1-142	1-1-143	1-1-144
1-1-145	1-1-146	1-1-147	1-1-148	1-1-149	1-1-150
1-1-151	1-1-152	1-1-153	1-1-154	1-1-155	1-1-156
1-1-157	1-1-158	1-1-159	1-1-160	1-1-161	1-1-162
1-1-163	1-1-164	1-1-165	1-1-166	1-1-167	1-1-168
1-1-169	1-1-170	1-1-171	1-1-172	1-1-173	1-1-174
1-1-175	1-1-176	1-1-177	1-1-178	1-1-179	1-1-180
1-1-181	1-1-182	1-1-183	1-1-184	1-1-185	1-1-186
1-1-187	1-1-188	1-1-189	1-1-190	1-1-191	1-1-192
1-1-193	1-1-194	1-1-195	1-1-196	1-1-197	1-1-198
1-1-199	1-1-200	1-1-201	1-1-202	1-1-203	1-1-204
1-1-205	1-1-206	1-1-207	1-1-208	1-1-209	1-1-210
1-1-211	1-1-212	1-1-213	1-1-214	1-1-215	1-1-216
1-1-217	1-1-218	1-1-219	1-1-220	1-1-221	1-1-222
1-1-223	1-1-224	1-1-225	1-1-226	1-1-227	1-1-228
1-1-229	1-1-230	1-1-231	1-1-232	1-1-233	1-1-234
1-1-235	1-1-236	1-1-237	1-1-238	1-1-239	1-1-240
1-1-241	1-1-242	1-1-243	1-1-244	1-1-245	1-1-246
1-1-247	1-1-248	1-1-249	1-1-250	1-1-251	1-1-252
1-1-253	1-1-254	1-1-255	1-1-256	1-1-257	1-1-258
1-1-259	1-1-260	1-1-261	1-1-262	1-1-263	1-1-264
1-1-265	1-1-266	1-1-267	1-1-268	1-1-269	1-1-270
1-1-271	1-1-272	1-1-273	1-1-274	1-1-275	1-1-276
1-1-277	1-1-278	1-1-279	1-1-280	1-1-281	1-1-282
1-1-283	1-1-284	1-1-285	1-1-286	1-1-287	1-1-288
1-1-289	1-1-290	1-1-291	1-1-292	1-1-293	1-1-294
1-1-295	1-1-296	1-1-297	1-1-298	1-1-299	1-1-300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 9 0 7 4			
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
Wendell Wilson Freeman				November 6, 1980			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		BLACK		MONTH DAY YEAR July 2, 1938		42 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		United States				Kent MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Chestertown		Kent & Queen Anne's Hospital		Warehouse Manager			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. STREET ADDRESS			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Maryland Kent Worton				Route 1, Box 377			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
Jefferson Freeman				Maggie Serena Butler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes				1961-1963		220-32-8821 Hospital Records, Chestertown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) OLD AND RECENT MYOCARDIAL INFARCTION							
4440							
DUE TO, OR AS A CONSEQUENCE OF							
(b) SHOCK DUE TO SPINAL CORD INFARCTION DUE TO							
3 HR							
DUE TO, OR AS A CONSEQUENCE OF							
(c) LARGE THROMBUS POST-AORTIC WALL (ABDOMINAL)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from November 5, 1980, to November 6, 1980, that (I) (we) lost saw the deceased alive on November 6, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE						22c. DATE SIGNED	
Harry Paul Ross M.D.						11-7-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS	
Harry Paul Ross M.D.						Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		11-11-1980		MT. OLIVE CEM.		WORTON KENT MD	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ernest W. Chertown, Md.				NOV 12 1980		Barry McCurdy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 9 0 7 5			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Clarence Webster Goldsborough				MONTH DAY YEAR November 5, 1980			
3 SEX Male				2b. HOUR 10:45 P.M.			
4 RACE Negro				5. DATE OF BIRTH			
MONTH DAY YEAR March 21, 1902				6 AGE (IN YEARS LAST BIRTHDAY)			
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland				7b. CITIZEN OF WHAT COUNTRY? United States			
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Kent			
10 CITY OR TOWN OF DEATH Chestertown				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland				13b. COUNTY Queen Anne's			
13c. CITY OR TOWN Queen Anne's Church Hill				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME Charles				15. MOTHER'S MAIDEN NAME Elva Harrietta Anthony			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 217-01-7435			
17 INFORMANT Hospital Records, Chestertown, Maryland				ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure - 2°</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Lung</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>October 30, 1980</u> to <u>November 5, 1980</u> , that (I) (we) lost saw the deceased alive on <u>November 5, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Patrick A. Molony M.D.</u>				DEGREE <u>M.D.</u>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick A. Molony M.D.				22e. ADDRESS Chestertown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>B.</u>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <u>CHINA HILL</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Chestertown Kent Md</u>	
24. FUNERAL DIRECTOR NAME <u>Edna M. Hall</u>				25a. DATE REC'D. BY REGISTRAR <u>NOV 14 1980</u>			
ADDRESS <u>Edna M. Hall</u>				25b. REGISTRAR'S SIGNATURE <u>Patricia M. Hall</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 9 0 7 6	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST FLORENCE		MIDDLE		LAST GUSTAFSON		2. DATE OF DEATH MONTH DAY YEAR Nov. 9, 1980		2b. HOUR 10:35 PM	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug 9 1912		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lincoln, Del		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.					
10. CITY OR TOWN OF DEATH Betterton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home 106 1st. Ave.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Betterton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 106 1st Ave.			
14. FATHER'S NAME Charles P. Bradley						15. MOTHER'S MAIDEN NAME Efiza Donovan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 58 7251		17. INFORMANT ADDRESS Carl O. Gustafson Betterton, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ca brain with</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 years</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1980</u> to <u>July 1980</u> , that (I) (we) last saw the deceased alive on <u>July 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>C. Gottfried Baumann</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/10/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gottfried Baumann		22e. ADDRESS Chestertown, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/12/80		23c. NAME OF CEMETERY OR CREMATORY Still Pond Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Still Pond, Md.					
24. FUNERAL DIRECTOR NAME <u>Wells</u>		ADDRESS Chestertown, Md.		25a. DATE REC'D BY REGISTRAR NOV 17 1980		25b. REGISTRAR'S SIGNATURE <u>Wells</u>					



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 9 0 7 7
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marguerite White Hadaway			2a. DATE OF DEATH MONTH DAY YEAR Nov. 19, 1980		2b. HOUR 6:00 M	
3 SEX female	4 RACE USA	5 DATE OF BIRTH MONTH DAY YEAR July 22, 1895		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent Co. MD.		
10 CITY OR TOWN OF DEATH Lynch	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife & labor		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE Md.	13b. COUNTY Kent	13c. CITY OR TOWN Lynch	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Main St.		
14 FATHER'S NAME FIRST MIDDLE LAST Thomas H. White		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine C. Knotts				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 220 16 9833		17 INFORMANT ADDRESS Francis Buckley Chestertown, Md.		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	---

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-30, 19 75 , to 11-19, 19 80 , that (I) (we) last saw the deceased alive on 11-19, 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			

23a. SIGNATURE <i>Robert W. Farr</i>	DEGREE	ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN	22c. DATE SIGNED 11/20/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr	22e. ADDRESS Chestertown, Md.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/22/80	23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.
24 FUNERAL DIRECTOR NAME <i>William Wells</i>	ADDRESS Chestertown, Md.	25a. DATE REC'D. BY REGISTRAR NOV 25 1980	25b. REGISTRAR'S SIGNATURE <i>Robert W. Farr</i>

100-29071

RECEIVED
FEB 10 1964



TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows]

RE: [Illegible]
[Illegible text follows]

[Illegible text follows]

[Illegible text follows]

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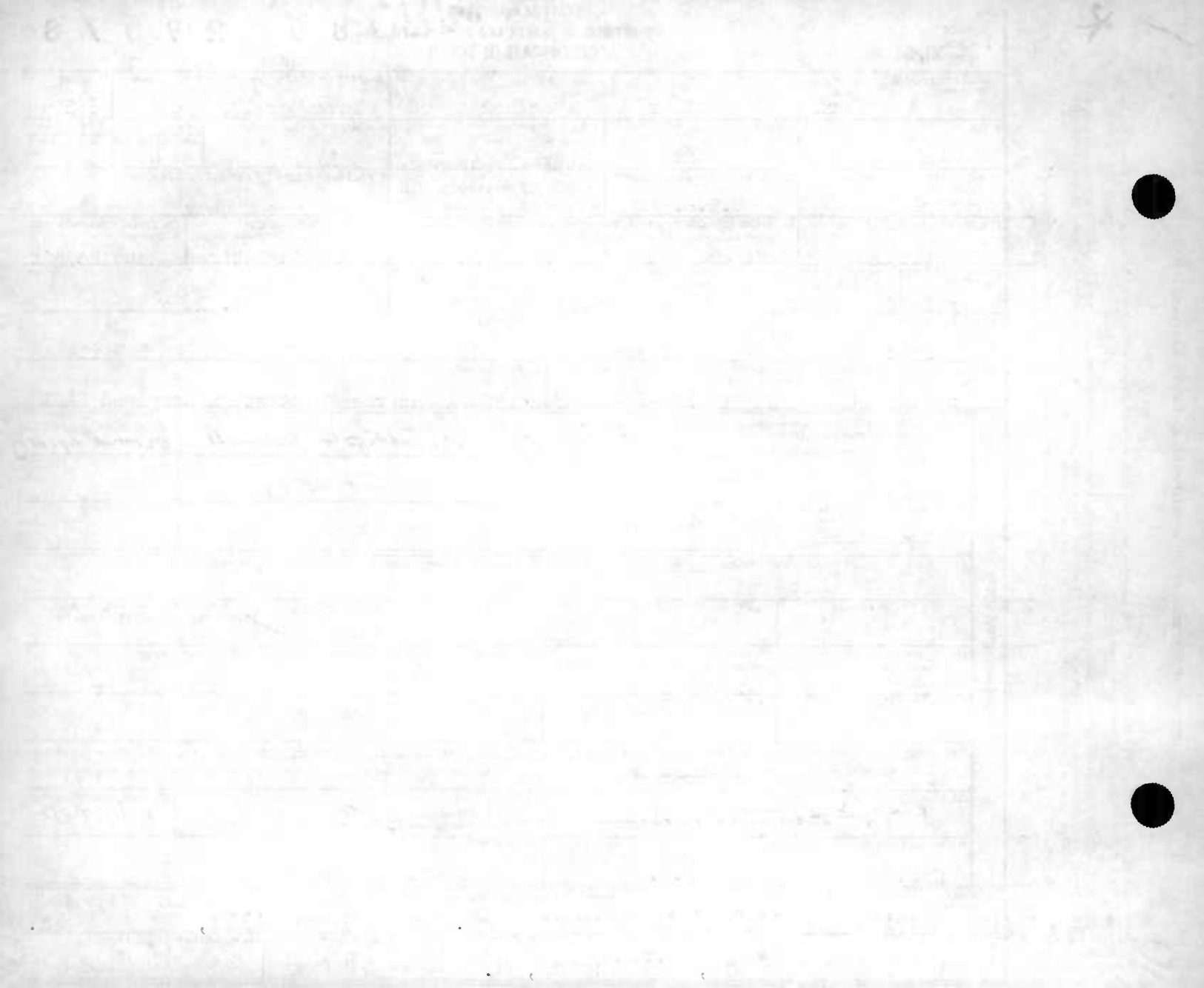
[Illegible text follows]

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	9	0	7	8
FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Carl Arthur Hofberg										2a. DATE OF DEATH MONTH DAY YEAR November 10, 1980				2b. HOUR 6:20p m		
3 SEX Male			4 RACE White			5. DATE OF BIRTH MONTH DAY YEAR February 24, 1899			6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH D Kent County MD.							
10 CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic-Retired			12b. KIND OF BUSINESS OR INDUSTRY Auto Repair			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Kent			13c. CITY OR TOWN Kennedyville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 1 Box 55				
14 FATHER'S NAME FIRST MIDDLE LAST Alick NMN Hofberg					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna NMN Roberts											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 175-28-1830			17 INFORMANT ADDRESS Hospital Records-Chestertown Maryland 21620										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <i>ISCVD - multiple small strokes</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Strokes</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>October 28</u> , 19 <u>80</u> , to <u>November 10</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>November 10</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Gottfried C. Baumann</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/11/80						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gottfried C. Baumann M.D.						22e. ADDRESS Chestertown, Maryland										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/13/80			23c. NAME OF CEMETERY OR CREMATORY Edgewood Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Glenn Mills, Pa.							
24. FUNERAL DIRECTOR NAME ADDRESS Edward Fellows & Son, Millington, Md.						25a. DATE REC'D. BY REGISTRAR NOV 19 1980		25b. REGISTRAR'S SIGNATURE <i>Robert A. Chesley</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 9 0 7 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Frank NMN Kelly Jr.				2a. DATE OF DEATH November 22, 1980		2b. HOUR 2:18A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH October 9, 1935		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service Spec.		12b. KIND OF BUSINESS OR INDUSTRY Products Petroleum	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Kent		13c. CITY OR TOWN Chestertown	
14. FATHER'S NAME Frank				15. MOTHER'S MAIDEN NAME Mary Anderson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.				16b. SOCIAL SECURITY NO. 220-32-1979		17. INFORMANT ADDRESS Hospital Records, Chestertown, Maryland 21620	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable Myocardial Infarction, acute</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 1 hour < 1 hour	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>November 22, 1980</u> , to <u>November 22, 1980</u> , that (I) (we) lost the deceased alive on <u>November 22, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Susan K. Ross M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/24/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan K. Ross, M.D.				22e. ADDRESS Chestertown, Maryland 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/25/80		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall, Kent, Md.	
24. FUNERAL DIRECTOR NAME Edward Fellows & Son, Millington, Md.				25a. DAY RECEIVED BY REGISTERAR DEC 1 1980		25b. REGISTERAR'S SIGNATURE [Signature]	

DEC 1 1980

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M7/77

FOR
1- STATE REGISTRAR
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE OF DEATH ESTIMATED		MONTH		DAY		YEAR		2d. HOUR	
Walter Flavius McCaleb								11-24 19 80								3:47 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		7d. HOUR	
Male	White	3-4-12		68 YRS.				11-24 19 80								9:00 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Texas		USA				Kent											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
near Millington		Highway 301 Kent & Queen Anne Hosp.		Retired Insurance Agency													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Florida		Lee Co.		Fort Myers				585 Valmar Drive									
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Walter F. McCaleb, Sr.		Marie Ideale McCaleb															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no		228 12 1353		Jack Doughty - Exmore, Va.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple severe injury to head, chest, and</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) <u>abdominal extremities</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		Auto accident, head on collision.															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		3:47 M. 11-24 19 80		Auto accident													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
		U.S. 301 2 miles south of MD Rt. 313,		Kent, Maryland													
22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Robert W. Farr, M.D.		Deputy		11-25-80													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Robert W. Farr, M.D.		Chestertown, Maryland															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Cremation		11/26/80		Silverbrook Crematory		Wilmington, Del.											
24. FUNERAL DIRECTOR		ADDRESS		25. DATE REG'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
J. Willard Wells		Chestertown, Md.		NOV 28 1980		Anthony McElroy											

L. O. V.

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE DISTRICT OF COLUMBIA

Case No. 100-100000-100000
Plaintiff, *[illegible]*
vs.
Defendant, *[illegible]*
The undersigned, *[illegible]*, Clerk of the Court, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the files of the Court.

Witness my hand and the seal of the Court at Washington, D.C., this *[illegible]* day of *[illegible]*, 19*[illegible]*.

[Signature]
Clerk of the Court

NOV 28 1980
U.S. DISTRICT COURT
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 9 0 8 1			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST William Cooper Meredith				MONTH DAY YEAR November 19 1980			
3 SEX Male				4 RACE White		5. DATE OF BIRTH April 06 06	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
10 CITY OR TOWN OF DEATH Chestertown				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Kent And Queen Anne's Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County	
12a. USUAL OCCUPATION Retired Marine Engineer				12b. KIND OF BUSINESS OR INDUSTRY Merchant Marines			
13a. STATE Maryland				13b. CITY OR TOWN Rock Hall		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Frank DEC. Meredith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Cooper			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 212-05-5367		17. INFORMANT Hospital Records, Chestertown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CUA -</u> <u>4360</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). _____							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>October, 19 80</u> to <u>November, 19 80</u> saw the deceased alive on <u>November, 19 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>C. Gottfried Baumann</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/21/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gottfried Baumann, M.D.				22e. ADDRESS Chestertown, Maryland 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11/22/80		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	
24. FUNERAL DIRECTOR NAME <u>William Wells</u>				ADDRESS Chestertown, Md.		25. DATE RECEIVED BY REGISTRAR NOV 25 1980	
						25b. REGISTRAR'S SIGNATURE <u>P. McCreedy</u>	

death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 9 0 8 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FRANCIS MUNKASEY			Oct. 26, 1980			10 M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	white	Sept. 27, 1904	76 YRS.			MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Hungary	USA		Kent MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Chestertown	Magnolia Hall Nursing Center		Exec. Electroph Corp.					
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS		
Md.			Queen Anne			Chestertown		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
Ferenz Munkasey			Ludmilla Beres			16b. SOCIAL SECURITY NO. 085 09 5436		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA of Rectum 1541 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		
Mildred Munkasey			Box 341 Chestertown Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (the hospital) attended the deceased from 1975 to 10, 1980, that (1) (me) last saw the deceased alive on 10/1/80, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (1) (me) (did not) view the body after death.			22b. SIGNATURE Wayne D. Benjamin			22c. DATE SIGNED 10/26/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		
Wayne D. Benjamin			Chestertown, Md.			Released on 10/26/80 to Anatomy Board Of Maryland Baltimore, Md.		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
J. Will Wells			OCT 30 1980			R. W. McCreedy		

(continued)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	9	0	8	3
1 - FOR STATE REGISTRAR										REG. NO.						
1 DECEASED NAME (TYPE OR PRINT) Edna M. Straughn										2a. DATE OF DEATH MONTH DAY YEAR Nov. 8, 1980				2b. HOUR 4:30 P M		
3 SEX female			4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR August 4, 1896			6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Q.A. CO. Md.			7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Kent MD.								
10 CITY OR TOWN OF DEATH Rock Hall			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home Beach Road					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gen. Chem. Various			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.			13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Beach Road						
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Murray					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Va. DeBaker Pinder											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 192 13 5662		17. INFORMANT ADDRESS Mrs. Va. Squibb - Rock Hall, Md.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASHD</u> <u>4140</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AGE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS.</u>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 11/8/80</u> to <u>11/8/80</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/8/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>H. Calvin Kaufman</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 11/9/80						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Calvin Kaufman					22e. ADDRESS Rock Hall, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/11/80		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall, Md.								
24. FUNERAL DIRECTOR NAME <u>W. Wells</u>					ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR NOV 17 1980		25b. REGISTRAR'S SIGNATURE <u>W. Wells</u>						

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1. STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 2 9 0 8 4		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MARTIN WAGNER				2a. DATE OF DEATH MONTH DAY YEAR Nov. 18, 1980		2b. HOUR 12:30 AM P	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR March 25, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co. MD.	
10. CITY OR TOWN OF DEATH Rock Hall		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION At home near Rock Hall		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Wagner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Satterfield			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 2 8 74 0691 A		17. INFORMANT ADDRESS Mrs. Florence Wagner (Above)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASHP. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							19. DATE OF OPERATION
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							21d. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							22b. SIGNATURE H. Calvin Kaufman M.D. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22c. DATE SIGNED							22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. CALVIN KAUFMAN M.D.
22e. ADDRESS Municipal Building, Rock Hall, Md. 21661							23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
23b. DATE 11/21/80							23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery
23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall, Md.							24. FUNERAL DIRECTOR NAME J. Wells Wells
25a. DATE REC'D. BY REGISTRAR NOV 25 1980							25b. REGISTRAR'S SIGNATURE R. Kelly Kelly



(Address)

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 9 0 8 5			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
James Edward White				November 3, 1980			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		November 17, 1895		84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				Kent County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Chestertown		Kent and Queen Anne's Hospital		Farmer			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland				Kent		Rock Hall	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Harry Walter White				Nora Ella Crew			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
No				213-18-5985		Hospital Records, Chestertown, Maryland 21620	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD 4292 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 9 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from September 26, 1980, to November 3, 1980, that (I) (we) last saw the deceased alive on November 3, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
C. Gottfried Baumann, M.D.		M.D.				11/21/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
C. Gottfried Baumann, M.D.		Chestertown, Maryland 21620					
23a. BURIAL, CREMATION, REMOVAL (SEE ITEM 1)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		11/5/80		Wesley Chapel Cem.		Rock Hall, Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. Wells Wells		Chestertown, Md.		NOV 6 1980		[Signature]	

MEDICAL CERTIFICATION

[Faint, illegible text across the page, possibly bleed-through from the reverse side. Some faint words like "and" and "the" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 9 0 8 6 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Russie E. Wilson Williams				2a. DATE OF DEATH MONTH DAY YEAR Nov. 29, 1980				2b. HOUR M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR June 4, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.					
10. CITY OR TOWN OF DEATH Worton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nursing		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY Kent		13c. CITY OR TOWN Worton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST James Wilkerson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adeline				13e. STREET ADDRESS R. F. D. #1 Box 386			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-07-1719		17. INFORMANT ADDRESS Mrs. Lucille Rauls Worton, Md.				R. F. D. #1 Box 386			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Cerebral ischemia due to bilateral carotid stenosis aggravated by pump failure.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Thomas J. Solon M.D.				DEGREE M.D.				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Solon M.D.				22e. ADDRESS 500 Kent Street Chestertown, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/4/80		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive A.M.E.		23d. LOCATION CITY OR TOWN Worton		COUNTY Kent		STATE Md.	
24. FUNERAL DIRECTOR NAME Thomas W. Solon				ADDRESS Chestertown, Md.				25a. DATE REC'D. BY REGISTRAR DEC 8 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 0 2 9 0 8 7			
1. FOR STATE REGISTRAR					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Walter Rasin Woodall Sr.			2a. DATE OF DEATH MONTH DAY YEAR November 18 80		2b. HOUR 6 am			
3. SEX male		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov 16 1905		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent		
10. CITY OR TOWN OF DEATH Galena, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ret. Farmer		12b. KIND OF BUSINESS OR INDUSTRY agriculture		
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Galena, Md.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Walter R. Woodall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Schofield				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 215-36-2079		17. INFORMANT ADDRESS Mildred Woodall -wife- (same)				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the left lung Squamous cell 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH three years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION 79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ga of the lung metastatic			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Feb 1978 , 19_____, to 18 Nov 80 , 19_____, that (I) (we) last saw the deceased alive on November 18 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Wallace O. Benshain M.D.				DEGREE MD		22c. DATE SIGNED 18 Nov 80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace O. Benshain, M.D.				22e. ADDRESS Cecilton, M				
23a. BURIAL, CREMATION REMOVAL (SPECIFY) cremation		23b. DATE 11/19/80		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, N.C. Del.		
24. FUNERAL DIRECTOR NAME Edw. Fellows and Son				ADDRESS F.H. Millington		DATE RECEIVED BY REGISTRAR 25. REGISTRAR'S SIGNATURE NOV 24 1980		

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